BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MICHELLE LYNN KEMMER 106 5TH Street Brookville, PA 15825 Registered Nurse License No. 754744 Respondent.	Case No. 2012-351 OAH No. 2012030830

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on March 18, 2013.

IT IS SO ORDERED this 16th day of February, 2013.

Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF REGISTERED NURSING
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MICHELLE LYNN KEMMER, Registered Nurse License No. 754744, Respondent.	Case No. 2012-351 OAH No. 2012030830

PROPOSED DECISION

This matter was heard before Karl S. Engeman, Administrative Law Judge, Office of Administrative Hearings, State of California, on November 28, 2012, in Sacramento, California.

Karen Denvir, Deputy Attorney General, represented complainant.

Respondent Michelle Lynn Kemmer appeared and represented herself.

Evidence was received, the record was closed, and the matter was submitted on November 28, 2012.

FACTUAL FINDINGS

1. Louise R. Bailey, M.Ed., RN (complainant) brought the accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer affairs, State of California.

2. On July 13, 2009, the Board issued Registered Nurse License Number 754744 to respondent Michelle Lynn Kemmer. Respondent's registered nurse license was in effect at all times relevant to the charges brought herein and expired on April 30, 2011.

3. Dilaudid, a trade name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and is a dangerous drug pursuant to Business and Professions Code section 4022 in that it requires a prescription pursuant to federal and state law. "Morphine" is a Schedule II controlled

pursuant to Health and Safety Code section 11055, subdivision (b)(1) (M), and is a dangerous drug pursuant to Business and Professions Code section 4022 in that it requires a prescription pursuant to federal and state law.

4. On or about August 10, 2010, respondent began working as a "traveler nurse" for Dignity Health at Mercy San Juan Hospital in the hospital's emergency room. Her contracting agency placed her there for a period that was supposed to run until September 26, 2010. During the period relevant to the causes of discipline, respondent was working the night shift from 6:45 p.m. until 7:15 a.m. in the emergency room. On or about September 20, 2010, Michelle Pagel, the manager of the emergency department at Mercy San Juan Hospital, received a report that respondent had asked another registered nurse to sign that she had observed the "waste" of unused controlled substances by respondent when the nurse had not been present when the disposal of the unused portion supposedly took place. Hospital policy required that at least two nurses witness the waste and sign that they had done so. Ms. Pagel asked the Pharmacy Director to audit the hospital records relating to respondent's withdrawal and administration of controlled substances. The audit revealed discrepancies that led to the cancellation of respondent's contract. Ms. Pagel communicated the discrepancies to the Board and the Board's investigative staff asked her to document the last six instances. Those six were the bases for the causes for discipline in the Accusation and are detailed below.

5. The administration of controlled substances by nurses at Mercy San Juan Hospital involved two computerized systems, the Omincell and the Electronic Medical Record (EMR). The drugs were stored in the Omnicell that was accessed by nurses entering their individual identification and passwords. The nurses chose the patient for whom they required medication and the proper medication to be administered. Controlled substances administered in the emergency room required a written order from a physician, physician's assistant or nurse practitioner. Verbal orders and "standing orders" would not suffice for the administration of controlled substances. The Omnicell recorded the nurse withdrawing a medication, including the dose, date and time. Upon administration, the nurse was to access the EMR using a separate identification and password and record the administration in the portion of the electronic chart known as the Medication Administration Record (MAR). As noted above, unused amounts of controlled substances were to be wasted by crushing pills and flushing them and squirting unused liquid medications in a receptacle with two nurses witnessing the event and using an electronic signature verifying they had done so. The records reviewed by Ms. Pagel were derived from the Omnicell and MAR.

Patient A

6. Respondent on September 20, 2010, at 7:00 a.m., withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell for this patient. There was no health provider order for administering the medication at this time and respondent did not chart the administration of the medication in the patient's MAR.

Patient B

7. Respondent on September 8, 2010, at 7:07 p.m., withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell for this patient. There was no health provider order for administering the medication at this time and respondent did not chart the administration of the medication in the patient's MAR.

Patient C

8. Respondent on September 5, 2010, at 11:39 p.m., withdrew a 4 mg/1ml syringe of Morphine from the Omnicell for this patient. There was a health provider order for administering this medication as needed no more often than once an hour and this withdrawal was only 43 minutes after the previous withdrawal. Respondent did not chart the administration of the medication in the patient's MAR.

Patient D

9. Respondent on September 19, 2010, at 2:35 a.m., withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell for this patient. There was no health provider order for administering the medication at this time and respondent did not chart the administration of the medication in the patient's MAR.

Patient E

10. Respondent on September 19, 2010, at 4:18 a.m., withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell for this patient. There was no health provider order for administering the medication at this time and respondent did not chart the administration of the medication in the patient's MAR.

Patient F

11. Respondent on September 19, 2010, at 7:00 a.m., withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell for this patient. There was no health provider order for administering the medication at this time and respondent did not chart the administration of the medication in the patient's MAR.

12. Respondent testified at the administrative hearing. She claimed that the discrepancies outlined above were the result of withdrawing medications for at least one patient, and perhaps two, under the wrong patient listing in the Omnicell. In some of the other cases, she claimed that she could not access the MAR in the electronic patient records because her password did not work. She also testified that in some unspecified instances, she simply did not diligently record the administration of the controlled substances in the MAR because she was too busy. Other evidence established that on occasions when respondent

claimed she could not access the MAR, she had successfully recorded the administration of non-narcotic medications. Respondent also mentioned verbal orders received for drugs, but as noted above, the emergency room protocols did not allow for the administration of controlled substances with verbal or "standing orders." In summary, respondent's explanations were not credible and the facts support the inference that she unlawfully obtained and possessed the drugs on the occasions detailed above.

13. Respondent's charted the withdrawal of the controlled substances for the purported administration to the specified patients as a subterfuge for obtaining and possessing them. This constituted falsification and the making of grossly incorrect entries in hospital and patient records pertaining to controlled substances and dangerous drugs. Respondent's charting of the withdrawal of the drugs without a provider order and without any corresponding record of administration constituted the making of grossly inconsistent and unintelligible hospital and patient records pertaining to controlled substance and dangerous drugs.

Mitigation and Rehabilitation

14. Respondent has been a registered nurse for approximately 20 years. She has never been previously disciplined. She obtained her nursing degree from Clarion University in Clarion, Pennsylvania, the state in which she lives with her husband of 23 years. They have three children, two of whom are adults. Respondent was employed by the same agency, Trustaff Travel Nurses, LLC, as a "traveling nurse" for five years at the time of the incidents described above. Since the Mercy San Juan Hospital jobs, she completed three other contracts without problems. Respondent has not worked as a registered nurse since December 29, 2011, because of the pending Accusation. She was enrolled in a master's degree program at LaRoche College in Natrona Heights, Pennsylvania, but took a leave of absence with the pending disciplinary action. Two "Letters of Reference" from an Assistant Professor and the Manager of the Emergency Room at Clarion Hospital, which is associated with the master's program, rated respondent as "excellent" in all subcategories of clinical judgment, personal attributes, and educational activities in early 2008. A charge nurse at Mount Nittany Medical Center in State College, Pennsylvania, wrote on June 10, 2009, that respondent was a skilled nurse who gave excellent care to her patients. A nursing colleague at Kidney Care Services in Brookville, Pennsylvania, wrote on June 5, 2009, that respondent demonstrated excellent knowledge and skill and provided excellent patient care. In addition to California and Pennsylvania, respondent holds nursing licenses in Florida, Virginia, West Virginia, and Montana. Respondent was under a great deal of stress at the time of the incidents above because her mother was dying in Florida.

15. As is implicit from the findings above, respondent denied any improprieties in the acquisition of controlled substances from Mercy San Juan Hospital. She remarked that she did not wake up one morning and decide to become a drug addict. Given her denial of the established conduct, it is impossible to appreciate what led her to take the drugs and whether respondent has attempted to deal with whatever circumstances or emotional

condition may have triggered the events after decades of apparently exemplary and ethical performance as a nurse. Without such evidence, the only reasonable disposition of this matter is the revocation of respondent's California license.

16. Complainant established that the actual costs for investigation and prosecution of this matter were $13, 250.25. The reasonableness of such costs in this matter is addressed in the Legal Conclusions below.

LEGAL CONCLUSIONS

1. Section 2761, subdivision (a), reads:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct...

2. Section 2762, subdivisions (a) through (e), reads:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

3. Business and Professions Code section 4060 reads:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to

Section 2746.1, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either Section 4052.1 or 4052.2. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

4. Health and Safety Code section 11173, subdivision (a), reads:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, ...

5. Respondent is subject to discipline pursuant to Business and Professions Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined by Business and Professions Code section 2762, subdivisions (a) and (e), in that she obtained controlled substances and dangerous drugs in violation of Health and Safety Code section 11173, subdivision (a), and Business and Professions Code section 4022 by reason of Factual Findings 4 through 14.

6. Section 125.3 authorizes the Board to request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

7. The actual costs of investigation and prosecution of this matter were $13,250.25 and respondent is subject to an order directing her to pay such costs in accordance with Business and Professions Code section 125.3 if such costs are reasonable. The case of *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 sets forth the factors which must be considered in determining the reasonableness of costs. Those factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay and whether the scope of the investigation was appropriate to the alleged misconduct. Here, respondent was unsuccessful in getting any charges dismissed or reduced. She did not demonstrate a good faith belief in the merits of her position, which was denial in the face of overwhelming evidence supporting her culpability. She failed to raise a colorable challenge to the proposed revocation of her license, presenting nothing to demonstrate rehabilitation form whatever condition caused her

to divert the narcotics. Respondent has not worked for approximately one year, so it may be inferred that her financial situation may not allow for the payment of a significant cost award. The scope of the investigation and prosecution, as reflected in the costs sought, appears reasonable. All criteria considered, the cost award is reduced to $10,000.

ORDER

1. Registered Nurse License Number 754744 issued to respondent Michelle Lynn Kemmer is hereby revoked.

2. Respondent shall pay the Board of Registered Nursing the sum of $10,000 in a manner and on terms deemed acceptable by the Board in the exercise of its discretion.

DATED: December 21, 2012

KARL S. ENGEMAN
Administrative Law Judge
Office of Administrative Hearings

Exhibit A

Accusation Case No. 2012-351

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHELLE LYNN KEMMER** **106 5th Street** **Brookville, PA 15825** **Registered Nurse License No. 754744** Respondent.	Case No. 2012-351 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about July 13, 2009, the Board issued Registered Nurse License Number 754744 to Michelle Lynn Kemmer ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and expired on April 30, 2011, and has not been renewed.

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STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct....,

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, or veterinarian.

8. Health and Safety Code section 11173, subdivision (a) states:

> No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

10. **CONTROLLED SUBSTANCES**

"Dilaudid" is a trade name for hydromorphone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

"Morphine" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

FIRST CAUSE FOR DISCIPLINE

(Obtain and Possess Controlled Substances in Violation of Law)

11. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between September 5, 2010 and September 20, 2010, while on duty as a registered nurse at Mercy San Juan Hospital, Carmichael, California, Respondent committed the following acts:

a. Respondent obtained the controlled substances Dilaudid and Morphine by fraud, deceit, misrepresentation, or subterfuge by taking the drugs from hospital supplies in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed the controlled substances Dilaudid and Morphine without lawful authority in violation of Code section 4022.

SECOND CAUSE FOR DISCIPLINE

(Falsify, or Make Grossly Incorrect Entries in Patient/Hospital Records)

12. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that while on duty at Mercy San Juan Hospital, Carmichael, California, Respondent falsified, made

grossly incorrect, grossly inconsistent, or unintelligible entries in the following patient/hospital records:

Patient A

a. On September 20, 2010, at 0700 hours, Respondent withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

Patient B

b. On September 8, 2010, at 1907 hours, Respondent withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

Patient C

c. On September 5, 2010, at 2339 hours, Respondent withdrew a 4 mg/1ml syringe of Morphine from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

Patient D

d. On September 19, 2010, at 0235 hours, Respondent withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

Patient E

e. On September 19, 2010, at 0418 hours, Respondent withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

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Patient F

f. On September 19, 2010, at 1930 hours, Respondent withdrew a 2 mg/1ml syringe of Hydromorphone from the Omnicell system for this patient; however, there was no physician order for this medication. Respondent failed to chart the wastage or otherwise account for the disposition of this medication in any patient/hospital record.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 754744, issued to Michelle Lynn Kemmer;

2. Ordering Michelle Lynn Kemmer to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: December 7, 2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant